A Phenomenological Study: Understanding Registered Nurses Experiences Related to Dysfunctional Leadership in a Hospital Setting

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This phenomenological research study explored the experience so Registered Nurses exposed to perceived dysfunctional leadership behaviors. The study provides insights into the phenomenon and how participants of the study were able to cope and adapt to the experience. Four major themes emerged from the research: 1.) The dysfunctional leader's approach to leading, 2.) The dysfunctional leader's competence and leadership attributes, 3.) The organization's competence related to addressing dysfunctional behaviors and 4.) The emerging of the phenomenon; the experiences of Registered Nurses exposed to dysfunctional leadership behaviors and how they made sense of their experiences.

INTRODUCTION

The social problem associated with dysfunctional workplace behaviors have taken several forms in recent years. Workplace bullying, narcissism, toxic, abusive, and tyrant behaviors have drawn a great deal of scholarly research (Einarsen, Hoel & Notelaers, 2009; Rosenthal & Pittinsky, 2006; Lubit, 2002; Kets d Vries, 2001, Tepper, 2000; Hornstein 1996). While workplace dysfunction is found in many industries it is predominant in the fields of healthcare, service industries, education, and social services. Dysfunctional workplace behaviors have touched all genders and races and causes harm to victims, bystanders, organizations and society as a whole. No one is immune to these behaviors.

Exploration of the literature establishes that nurses are a high-risk occupational group for a range of dysfunctional behaviors including workplace violence and aggressive behaviors in the healthcare setting (Rodwell, Brunettro, Demir, Shakclock, & Wharton, 2014; Hutchinson, Vickers, 2002; Hegney, Plank, & Parker, 2003). With increased stress and pressure healthcare is suspect for continued dysfunctional behaviors to continue. Despite being considered a substantial topic in literature, focusing primarily on dysfunctional behaviors with peers and co-workers, few studies have focused on dysfunctional interactions between direct reports and leadership (Tepper, Carr, Breaux, Geider, Hu, & Hua, 2009). Limited research exists related to understanding the insights and experiences of Registered Nurses exposed to dysfunctional leadership; specifically how they make sense of these experiences; a topic which has detrimental impact to healthcare (Rodwell, et al., 2014). This research study focused on a phenomenological approach to understand the lived experiences of Registered Nurses exposed to dysfunctional leadership in a hospital setting in the Chicago Metropolitan area.

BACKGROUND

Challenges Facing Healthcare

Healthcare organizations today are facing extreme pressures to lower costs while increasing quality. Further compounding the issue, healthcare leaders are faced with increased stress due to rapid changes in technology, ambiguity related to healthcare reform, decrease in reimbursements, nursing shortages, an aging population requiring complex care, and an increasingly large patient population that is not financially equipped to handle the rising costs of healthcare (Wramsten, Ahlborg, Jacobson, & Delve, 2014; Leatt & Porter, 2003). In addition healthcare organizations today live in lean times asking employees to do more with fewer resources. Healthcare continues to be held to higher levels of scrutiny and demands from the government, regulatory agencies, and educated consumers. It is vital that during this time of tremendous change, employees need to be engaged, motivated, focused and committed to the organization. Institutionalizing a healthy, motivated .and energized workplace can increase financial outcomes while also allowing for collaboration across the board within healthcare (Moore, Leahy, Sublett, & Lanig, 2013). Delmatoff and Lazarus (2014) declared "Healthcare leaders must understand the value and critical importance of delivering an emotionally and behaviorally intelligent style of leadership to ensure that their staff feel empowered and supported as they work through and implement some of the greatest changes in the delivery of health since the introduction of Medicare" (p. 245-246).

Challenges Facing Nursing Leadership

Many political, economic, and professional factors influence the essence of the nurse leadership role (Jooste, 2004). Plowman and Duchon (2008) asserted that traditional leadership theories and models are no longer acceptable in informing leadership behaviors in healthcare. A paradigm shift in leadership is needed in order to address the issues being face. No longer is the leader the one that controls the employee but, acts as a visionary leader, able to plan, organize, lead, and control activities (Jooste, 2004). Exemplary healthcare leadership is crucial during these times of change and significant upheaval (Anonson, Walker, Arries, Sithokozile, Telford, & Berry, 2014; Kilty, 2005).

A paradigm shift is difficult provided the lack of leadership training that is offered for nursing leaders making the transition from bed side nurses to leadership. Sanford (2011) identified that often nurses who are excellent clinical nurses are assumed to be strong leaders needing little to no development. Swearingen (2009) discussed that given the complexity of modern healthcare it is imperative to ensure that managers and leaders received adequate educational preparation and ongoing access to leadership development opportunities.

Nursing is one of the most necessary and vital fields in medicine today. They are the frontline care givers as well as the conduit between the patient and physician. Nurses need to focus on the care of the patient, providing quality outcomes along with the ability to navigate through the ambiguous and ever changing landscape. However, the nursing profession is not without its own issues and problems. In recent years compounding factors include the high turnover rate of nurses. Hart (2005) stated that at a turnover rate of 18-26%, nursing turnover is one of the highest of all professional occupations. One of the main factors leading to high turnover and job dissatisfaction is leadership. Leadership problems such as insufficient support, lack of follow through, and favoritism have increased dissatisfaction for nurses thereby resulting in higher turnover rates (Cline, Reilly & Moore, 2003).

While nursing turnover plays a significant role in organizational well-being it is also an indicator of more severe issues such as intention to withdraw from the nursing profession completely (Tummers, Groenevald, Lankhaar, 2013). In 2002, approximately 500,000 individuals held nursing licenses but were not actively working in the nursing profession (Nelson, 2002). In 2008, the number declined to approximately 465,600 licensed Registered Nurses who were not practicing (US Department of Health and Human Services, 2010). Speculations on why so many licensed nurses have left the profession include personal and family issues, job burnout, and stress related factors including dysfunctional work relationships between peers, physicians, and leadership (van der Heijden, van Dam, & Hasslehorn, 2009; Leatt & Porter, 2003).

A constant threat to healthcare organizations are the risks of dysfunctional behaviors which impact the ability to address the change that is desperately needed. The nurse leader is faced with challenges and changes which continue to stretch nursing leaders to their limits, causing them to feel alienated, angry, and powerless. These negative feelings can then be turned on colleagues and direct reports in the form of criticism, sarcasm, silence, or other dysfunctional behaviors including violence (Bower, 1997). Without powerful leadership development, nurse leaders base their leadership style on what they know and have experienced from past leaders, which may be dysfunctional behaviors (Bondas, 2006; Laurent, 2000). Roberts (1983) shared that nurse leaders often adopt the values and norms of dominating groups that they have been exposed to, believing that by doing so, they would gain power and control. In many cases nurse leaders become controlling, coercive and rigid in order to conform to the model that is predominate within the work environment (Matheson, 2008).

Types of Dysfunctional Leadership

In order to understand the role of dysfunctional leadership it is important to understand each of the different types of dysfunction that was focused on in this study. For the purpose of this study only narcissistic, abusive, and bullying leadership behaviors were highlighted. The following explains each of these dysfunctions in further detail.

Narcissistic Leadership

Kets de Vries (2001) defined narcissistic individuals as "troubled by their being, by a sense of deprivation, anger, and emptiness" (p. 101). King (2007) further expanded upon this definition as "a personal form of admiration" (p. 184). Rosenthal and Pittinsky (2006) added, "A perverse self-love. In order for the narcissist leader to cope with their insecurities, they may become fixated on power, status and superiority to others" (p. 618). Narcissists are also characterized as overly confident (Campbell, Goodie & Foster, 2004), arrogant (Paulhus, 1998), dominant (Emmons, 1989) and extraverted (Miller & Campbell, 2008). For some followers this approach to leadership may seem appealing.

Lubit (2002) explained that not all narcissistic behavior is negative. "We all have some degree and variety of narcissistic delusion" (Shengold, 1995, p. 29). Freud (1914), Kohut (1971), and Rothstein, (1980) found that normal or healthy narcissism is implied if the ego is relatively stable (Fine, 1986). Lubit (2002) described simply, that there are two types of narcissistic behavior. The first type of narcissistic behavior can be considered positive. Often referred to as constructive narcissistic leaders, utilizing power and status for positive influence and impact. Humphreys, Zhao, Ingram, Gladstone and Basham (2010) rationalized that the constructive narcissistic leader leads by empowering, enabling, and providing a positive vision. Some theories suggest that narcissism is an essential component of creativity, empathy, and the acceptance of loss, thereby adapting to change quite well (Frosh, 1991, p. 96). Narcissistic leaders have been touted as visionary innovators who can motivate the masses with rhetoric (Maccoby, 2000). Rosenthal and Pittinsky (2006) stated "The contrast between the harmful impact that narcissistic leaders can have on their constituents and institutions and the fact that narcissism is a key trait of the world's most creative and generative leaders seems to suggest that the concepts need to be studied and defined" (p. 628). Kets de Vries and Miller (1985) also supported this statement by explaining that narcissism may in fact be a fundamental element of leadership effectiveness.

The second type of narcissism is referred to as reactive narcissism. Macobby (2003) defined the reactive narcissist as extremely independent, highly distrustful, self-involved, and eventually causes the destruction of the leader, followers and organizations. Lubit (2002) further expanded on the definition by explaining that narcissistic leaders are preoccupied with their own importance. They can be considered exploitive, overly sensitive to criticism, arrogant and egocentric, with a sense of entitlement and lack of empathy towards others. (Morf & Rhodewalt, 2001; Rosenthal & Pittinsky, 2006). The reactive narcissist relishes the spotlight and will take credit even when the credit belongs to others (Kets de Vries, 2001). Their presence is often dominating and will not exude empathy towards their followers (Kets de Vries, 1999).

Abusive Leadership

Tepper (2000) explained abusive leadership behaviors as it relates to the subordinate's perception of hostile and negative leadership behaviors. These behaviors include: public criticism, use of derogatory names, condescending tones, intimidation, tantrums, rudeness, coercion, public ridicule, yelling, taking credit for subordinates' achievements, intimidating subordinates and blaming subordinates for mistakes they did not make (Hoobler & Brass, 2006; Tepper & Duffy, 2002). Ashforth (1997) acknowledged that abusive leaders use their power to mistreat and disrespect employees. The negative impact of this behavior is not limited to interactions with their subordinates, but also extends to interactions with other departments, and peers (Solano & Kleiner, 2003). Hornstein (1996) added that abusive leaders are primarily concerned with gaining and maintaining control and or power through fear and intimidation. Research conducted by Tepper, Duffy, Hoobler, and Ensley (2004) indicated that followers subjected this type of behavior experienced less commitment to their organization and were more likely to display increased turnover rates. Followers who experienced abusive leadership stated that they believed leadership was unjust and had a negative influence on their attitude toward work, the organization, and their work environment (Tepper, 2000).

Bullying Leadership

The social problem related to bullying in recent years has taken many forms. Workplace bullying has drawn a great deal of scholarly research in recent years (Einarsen, Hoel & Notelaers, 2009). Bond, Tuckey, and Dollard, (2010) stated "Workplace bullying is a serious and chronic workplace stressor that negatively impacts individuals and organizations" (p. 37). Espelage and Swearer, (2003) argued that "perhaps, the most challenging aspect of bullying prevention programming is reaching a consensus on a definition of bullying." (p.338). Definitions of bullying include repetitive actions intended to offend, behavior that devalues, humiliates, harasses, ostracizes and causes the victim stress by demonstrating hostile or aggressive behaviors (Barrow, 2010; Einarsen,1999). Bullying can take the form of blaming subordinates for errors, making unreasonable demands, attacking the victim's character and competence, threatening employees with termination, excessive monitoring of work, and insults (Yildirim & Yildirim, 2007; Naimie & Naimie, 2003).

Similar to abusive leadership, bullying occurs in all ranks of leadership, including middle management and executive leadership (Rayner & Cooper, 2007). Bullying and abusive leadership seem similar however abusive leadership differs from bullying as it is strictly hierarchical and may involve a single act, whereas bullying is repetitive with focus on intentional harm to the victim (Neuman, 2009). Greer and Schmelzle (2009) cited the 2007 US Workplace Bullying Survey which found that 37% of US workers were bullied at work. According to the Campaign Against Workplace Bullying one in five United States employees reported being victims of repeated workforce bullying (Naimie & Naimie, 2003). Workplace bullying is widespread (Needham, 2003) having devastating effects on an employee's life, family, and career (Naimie & Naimie, 2003). Vickers (2002) explored the dimensions related to bullying in the workplace and pointed out that bullying is not limited to one individual but can include groups, even functioning organizational units. Workplace bullying has a devastating impact on the individual and the organization (Quine, 2002).

Impact of Dysfunctional Leadership Behaviors

The impact of dysfunctional leadership has many components. The monetary costs to the United States exceeds $23 billion each year in employee healthcare costs, absenteeism, and lost productivity (Tepper, Duffy, Henle & Lambert, 2006). The effects of dysfunctional leadership reach far beyond the monetary costs identified. Blasé, Blasé and Du (2008) stated that the psychological and emotional impact of dysfunctional leaders include negative feelings such as: desperation, incompetence, embarrassment, guilt, and shame. These negative feelings often manifest themselves in physical reactions that have a harmful impact on the health and well-being of the followers.

Psychological Impact

The impact of dysfunctional workplace behaviors affects the target (also referred to as the victim), as well as bystanders witnessing the behavior, through psychological and or physical symptoms. The seriousness of physical and psychological abuse has been well documented (Barrow, 2010; Kusy & Holloway, 2009; Einarsen et.al., 2009; Einarsen & Raknes, 1997; Einarsen & Skogstad, 1996). Prolonged exposure to dysfunctional behavior often results in Post-Traumatic Stress Disorder (PTSD). Steele and Lee (2007) explained that workers that experience abuse or harassment on the job are likely to experience negative outcomes in a work setting such as decreased job satisfaction, lower organizational commitment, withdrawal from work, physical illness, mental health issues, and other symptoms of PTSD. Symptoms of PTSD include a.) Diminished energy (MacIntosh, 2005); b.) Anxiety (D'Cruz & Nronha, 2010); c.) Avoidance and d.) Depression (Malinauskiene & Einarsen, 2014). In addition to PTSD it has been noted that on occasion dysfunctional behaviors in the workplace have been associated with suicidal thoughts and attempts (Hinduja & Patchin, 2010). In a study of Turkish nurses, 10% of the respondents said they contemplated suicide because of dysfunctional behaviors (Yildirim & Yildirim, 2007).

Physical Impact

Stress has a negative impact on the physical well-being of individuals. Stress of dysfunctional situations can cause physical impairment to the victim as well as bystanders (Johnson, S. 2009; Einarsen & Mikkelsen, 2003). Physical symptoms of dysfunctional behaviors include but are not limited to the following: a.) Increased drug use, smoking and drinking; b.) Weight loss; c.) Fatigue; d.) Headaches; e.) Upper and lower GI symptoms; f.) Chest pain and heart palpitations, g.) increased obesity. (Youn, Bernstein, Mihyoung, & Nokes, 2014; Yildrim & Yildrim, 2007). As a result of physical illnesses victims exposed to dysfunctional leadership behaviors are more prone to miss work due to illness.

Organizational Impact

Unprofessional conduct exists at all levels within Healthcare (Swiggard, Dewey, Hickson, Finalysen, Spickard, 2009). When employees perceive the organization is responsible for the dysfunction and permitting the behavior, they will often be less satisfied with their job, have increased levels of absenteeism, higher quality issues, and decreased loyalty to the organization (Rodwell, Demir, & Steane, 2013). Dysfunctional behaviors in healthcare attribute to organizational issues such as turnover which, demonstrated earlier, is already taxing healthcare. Nurses exposed to dysfunctional leadership contemplate leaving the organization or the nursing profession as a whole (Lewis, 2006; Daiski, 2004).

METHOD

Based on an extensive review of the literature, it was determined that limited qualitative research existed focusing on the topic of dysfunctional leadership in Healthcare. Limited research specifically related to understanding the phenomenon associated to Registered Nurses exposed to dysfunctional leadership in a hospital setting was lacking. This study focused on the Phenomenological approach of Registered Nurses in a hospital setting in the Chicago Metropolitan area exposed to perceived dysfunctional leadership styles.

Sample and Procedure

The study sample was comprised of 18 Registered Nurses employed at 18 different hospital settings within the Chicago Metropolitan area. Since the field of Healthcare is so broad, the researcher chose to focus on Registered Nurses in a hospital setting who were identified as having experienced with leaders whom the nurses perceived as having dysfunctional leadership characteristics. A diverse population ensured an in-depth focus on the phenomenon. Purposeful selection was used to determine the sample. Certain criteria was imposed on the study, such as participants were required to be over the age of 21 and employed as a registered nurse in hospital setting in the Chicago Metropolitan area. If potential candidates were interested in the study they were invited to an online instrument for pre-screening purposes. The pre-

screening instrument asked participants if they were able to share experiences related to leaders they have been exposed to. The survey focused on a variety of dysfunctional leadership behaviors. Table 1 presents the questions asked in the instrument:

TABLE 1
PRE-SCREENING INSTRUMENT

Are you able to share experiences with a Healthcare leader who	Category
Was hostile towards you, displaying verbal and non-verbal negative comments or actions?	Abusive
Sabotaged your work or undermined you?	Bullying
Would steal the spot light and take credit for your work?	Narcissism
Repeatedly used abusive behavior such as threatening termination, insults and minimizing your accomplishment?	Abusive
I have never experienced a Healthcare leader that displayed negative behaviors	Opt out
I am unable or too uncomfortable to share my experiences	Opt out

The pre-screening instrument was open for the duration of four weeks; identifying 75 participants who completed attempted completion of the instrument. Of the 75 participants 41 shared that they had experienced some form of dysfunctional leadership behavior or behaviors; 24 participant indicated they were interested in participating in the interview phase of the study. As the emergent design evolved, 18 participants were interviewed for the study.

RESULTS

Four major themes emerged from the analysis of transcripts: 1.) The dysfunctional leader's approach to leading, 2.) The dysfunctional leader's competence and leadership attributes, 3.) The organization's competence related to addressing dysfunctional behaviors and 4.) The phenomenon's impact on the lived experiences of Registered Nurses exposed to dysfunctional leadership. The following discusses each of the themes in depth.

Theme 1: The Dysfunctional Leader's Approach to Leading

The perceived dysfunctional leader's approach to leading focused on how the leader's behaviors affected participants as well as discussion regarding the team and the organizational system. Several of the participants shared experiences with dysfunctional leadership behaviors that were destructive, abusive, narcissistic and ultimately detrimental to all involved including the organization system. Dysfunctional leadership behaviors were found to restrict team development and formation. Participants felt that the dysfunction often interfered with team formation and interactions resulting in teams that were fragmented and disconnected. However, interesting to note was that despite interference from the leader, many of the participants formed their own sub-teams or sub-culture in order to unite together to fight what they believed was the common enemy. As a result participants found power in their new formed unity which opposed the direction of the leader. This new found power was used against the leader; ultimately sabotaging the action of the leader with the goal of having the leader removed from the unit or the organization. In some of the cases the participants were successful and in others they were not resulting in negative consequences.

Participants of the study explained that in most cases the dysfunctional leadership behavior was not just limited to their area or unit but permeated several layers within the organization. They also felt that the leader was focused on promoting their own personal agenda at any cost to the organization or the individuals they were leading. Participants found leadership behaviors that were considered undermining,

belittling, lying, ostracizing, and sabotaging in order to discourage followers and to promote the leader's agenda. Several participants stated that the ego of the leader and the lack of finding a purpose to their work was causing them to question their calling. In many cases they stated that this "was not what I signed up for" and thoughts of leaving the nursing profession were discussed and often considered. What kept participants from leaving the organization was fear for other co-workers and what would happen to them.

Theme 2: Leader Competence and Leadership Attributes

The research study found that the participants of the study struggled with the inconsistent behavior of the dysfunctional leader. Participants believed that much of the dysfunction they experienced came from emotional issues such as stress due to lack of competence in their roles as a healthcare leader and inability to effectively manage or lead. They felt that the leaders were not equipped to handle the stress and demands placed on them. As a result many of the leaders would either act out in an aggressive manner or recoil and become passive under stress.

Confusion regarding lack of direction, vague expectations, and unpredictable leadership behavior caused additional stress for the participants. In a majority of the cases the participants felt that the leader was too far removed from the day to day role of the nurse and did not fully understand the clinical scope of nursing. In addition participants found leaders struggling with changing technology, financial pressures, endless meetings, all of which resulted in lack of engagement with direct reports on the part of the leader with the nursing staff.

As was found in the literature, many of the participants found that their leader was often a strong bedside nurse and eventually promoted without management or leadership training. To the participants it appeared their leadership did not have the support of the organization, seemed to lack mentoring and leadership development which may have caused leaders to struggle with their roles. The paradigm shift of moving from patient care and to one of a business mindset was a difficult transition for several of the leaders. As a result, the participants felt the pressure and lack of knowledge caused frustration on the part of the leader and employees.

Theme 3: The Organization's Competence Related to the Dysfunctional Experience

Participants shared interesting observations in regards to how the organization specifically centered on executive leadership and their lack of ability to address problems concerning dysfunctional leadership behaviors. Each of the participants shared that their organizations and executive leadership was aware of the dysfunction that was occurring. Participants found that the organizations chose to ignore the problem, hoping that the problem would resolve itself. Complaints regarding dysfunctional behaviors were escalated to Human Resources, other leadership team members and in some cases executive leadership team members including the Chief Nursing Officer or the Chief Executive Officer (CEO). It was perceived by the participants that their organizations either permitted the behaviors or they did not possess the skills needed to address dysfunctional behaviors. In some of the examples, when faced with a dysfunctional leader, organizations would rationalize the behavior as the leader doing what was needed for the organization and it was viewed as necessary for the success of the organization. This was especially true if the unit was a financially viable department showing strong financial performance. If this was the case, dysfunctional leadership behaviors were ignored.

Dysfunctional leadership caused the organization and the culture to suffer. The research found that cultures morphed to fit the behaviors of dysfunction. The higher the leader's status the more the culture would change to accommodate the dysfunctional behaviors demonstrated. In other examples, organizations purposely sought out leaders that were believed to change the organization. If the culture was already dysfunctional, senior leaders frequently hired leaders that possessed the same dynamics and personalities as the rest of the leadership team. This perpetuated the problem, causing the perfect storm. In other cases leaders were hired that were different from the culture; looking for someone who "could shake up the organization". By bringing in a leader that had opposite leadership styles than the executive leadership team, they believed that they were bringing in a new dynamic force that would change the

direction of the organization. In many cases the dynamics became further dysfunction, resulting in senior leaders rationalizing the behavior as a way for the leader to get done what needed to be done for the good of the organization; regardless of the methods that were used.

Theme 4: The Phenomenon's Impact on the Lived Experiences of Registered Nurses Exposed to Dysfunctional Leadership

The problem addressed in this study was to understand the phenomenon related to Registered Nurses exposed to dysfunctional leadership in a hospital setting. Theme 4 addressed the phenomenon as it emerged. Each of the 18 participants shared that they had experienced some form of emotional and or physical distress from the dysfunctional behaviors experienced. Distress manifested in many forms including emotional, physical, and spiritual. Each of the Registered Nurses in the study explained that they felt equipped to care for the needs and well-being of their patients but, lacked the skills to effectively care for themselves or to handle stress associated with a dysfunctional leader.

Resources were not available for participants to work through their experiences. Participants found Employee Assistance Programs (EAP) were a conflict of interest and also feared that experiences would be shared with upper leadership, ultimately resulting in retaliation. If EAP was utilized participants stated that the often counselor knew about that situation from others and recommendations were to lay low and keep out of sight of the dysfunctional leader. To find relief participants found outside support in the form of family, therapy, continuing education or spiritual care. Others found support in destructive behaviors including, recreational and prescription drug abuse, alcohol, overeating, bringing the stress home and causing conflict with loved ones. In four of the eighteen participants, contemplation of suicide was considered as a way to end pain and suffering experience.

Many of the participants stated that they continue to struggle with their experience with a dysfunctional leader. In some cases the leader has been out of their lives for a number of years but, participants stated they often relive the experiences. Many of the participants did not want to seek help and thought that they were crazy for these feelings.

DISCUSSION

Based on the findings of the research there is much that can be learned from an organizational standpoint to understand these experiences. Dysfunctional leadership impedes teamwork, affects communication, is detrimental to the culture of the organization and can be damaging to employees exposed to this type of leadership. The impact that dysfunctional leadership behavior has on direct reports as well as the organization is detrimental. The following provides further discussion to address these types of behaviors in healthcare.

Role of Executive Leadership

It is vital that executive healthcare leaders understand and address the implications of dysfunctional leadership. The need to address these behaviors is paramount to the success of healthcare both now and in the future. Clear expectations of acceptable behavior must be defined and communicated throughout the organization at all levels. One has to believe that while the study focused on Registered Nurses, this type of behavior is widespread and happening to other healthcare employees. Zero tolerance policies are essential and must be institutionalized as part of the culture.

Executive leaders require the skills necessary to address dysfunctional leadership behaviors. Even more important is the urgency in which these behaviors need to be addressed. Ignoring the problem will not aid the situation. Developing cultures with expectations on how to address these behaviors is the first step. Building a culture of accountability is the next step. Strong mechanisms that allow employees to report dysfunctional behavior in a safe environment is essential. While many healthcare organizations have implemented hotlines to report issues regarding patient safety, process problems as well as leadership issues, many times not enough information is provided to effectively follow up on issues. Investigations maybe conducted, however employees will not speak up due to fear of retaliation and the

cycle continues. Employees need to be assured that retaliation will not be permitted or tolerated. Utilization of outside mediators, coaching, and leadership development is an option that should be utilized. Development of skills that promptly address these behaviors ought to be implemented.

Executive leadership development programs in healthcare often address the tactical components of management and leadership such as strategic alignment, financial management, and building healthcare networks. Clear definition of healthy leadership behaviors and traits is a practice that is often ignored or assumed. Educational focus on leadership skill development is needed at all levels of leadership within healthcare. Focusing on education including stress reduction, burnout, effective relationship building, and empowerment is a critical component in building a healthy work environment.

One of the findings in the research study found that several of the leaders lacked competence in leadership, interpersonal leadership, and management skills. Ramoom, Abdullah, Piaw (2013) stated that nurses' social and professional relationships are salient predictors of nursing job satisfaction. Leadership development programs that are rooted in emotional intelligence and relationship building are required for successful nursing leadership. Today's healthcare leader's role is evolving and changing rapidly. In the past healthcare leadership was considered one-dimensional however, today's leadership model is multi-dimensional requiring leaders that are focused on relationship building, financial acumen, clinical outcomes and adaptability to address change.

Promotion of nurses into nursing leadership must be reconsidered. Having a strong clinical nurse does not equate to a competent and capable leader. While technically able to do the job, the nurse may not be equipped for the other components of leadership. Mentorship programs to help to develop and provide support to newly promoted nursing leaders should be examined. Navigating through complexity while building relationships can be stressful for a new leader. A strong mentor or support group of individuals should emulate the type of leadership characteristics and traits that promotes a healthy work environment.

Support

Support is critical for victims exposed to dysfunctional leadership. Psychological Safety is defined as a shared belief by employees of an organization that they are safe for interpersonal risk taking (Harper & White, 2013; Edmondson, 1999). Early studies (Edmondson, 1999, 1996) found that psychological safety in healthcare teams revealed that members of psychologically safe teams were more likely to discuss and report errors, learn from mistakes, and prevent recurrence. Higher levels of learning resulted in higher functioning team environments. In order for these components to be implemented, there is a need for strong support systems in place including Human Resources, mentorship programs, along with mechanisms to address stress, burnout, and dysfunction. All participants in the study felt that their organizations did not offer support systems that could be utilized. Providing avenues for employees to get support is critical for the health of the employee and the organization. Employee Assistant Programs or Counseling that is not associated with the healthcare organization is important. A third party support system, such as outside mediators, counseling, or coaching, will allow employees to find the support they need to cope as well as to feel safe in their environment.

Strengths, Limitations and Future Research

Strengths of the study focused on the actual lived experiences of nurses exposed to perceived dysfunctional leadership traits. As a result, the study was able to provide insights of how Registered Nurses made sense of their experiences. The research demonstrates how the participants coped with the situation; how they made sense of the experience; and how their organizations addressed the situation. The research provides another lens into the world of dysfunctional leadership and the understanding of the themes that emerged. Understanding the impact from a physical, psychological, and organizational component, organizations are able to understand the impact of ignoring the problem. The research provides a lens to understand qualitatively the themes that were experienced by the participants.

With any study there are limitations. The first limitation addresses geographic location. The geographic location of the Chicago Metropolitan area does not provide an adequate understanding of other locations throughout the US. We are unable to determine if these experiences are truly

representative of all geographical areas. In addition the research does not focus on any mitigating circumstances that may have been occurring within the organization or provide the insights of the leadership that is viewed as dysfunctional. Lipman-Blumen (2005) explained that one person's toxic leader is another person's hero. The study is limited by the insights of only a select few representatives of the experiences. The study does not take into account others within the same organization who are also exposed to the same behaviors and how they interpret the experience.

Future research is needed to further explore this phenomenon. Quantitative analysis exploring larger populations to provide insights on how predominant dysfunctional leadership is in regards to healthcare is required. Additional qualitative research of conversations with leaders to understand their experiences related to healthcare and their awareness of their behaviors is missing from the literature. A difficult topic to investigate as leaders may not be willing or even aware of influence regarding their behaviors. Nevertheless, it is important to understand the insights of leaders and perspectives which may differ from direct reports. Ultimately, an important topic to explore is the role that dysfunction plays in the care of the patient and patient outcomes.

Conclusion

Healthcare continues to be an environment that is primed with complexity. Nursing shortages, lack of qualified staff, new technology, healthcare reform and new regulations are only the start of the issues facing today's healthcare leaders. Leadership that is capable, caring, and focused on excellence is paramount in order for healthcare organizations to survive.

As the nation continues to face shortages of qualified Registered Nurses, healthcare organizations cannot afford to lose qualified nurses for the reason of dysfunctional leadership. Organizations are encouraged to explore the costs of turnover, absenteeism, medical errors and lower productivity to determine root causes. Through exit interview, employee satisfaction survey reports, patterns emerge that ascertain the reasons nurses are leaving. It is essential to look for patterns and address any dysfunctional behaviors that are occurring in units or the organization.

In a time when healthcare is facing tough challenges productivity and teamwork will be vital for success. The role nursing plays is pivotal in coupling all moving elements. Excellence in nursing leadership is the adhesive force that holds healthcare together. The ability to effectively address and deal with stress is pertinent for leadership and organizations. Healthcare employees desperately seeking capable leadership to guide them through this period. There is no room for dysfunctional leadership behaviors. Healthcare organizations and leadership must demonstrate commitment to creating a healthy work environments for employees which will ultimately impact the patient and patient care.

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